Bureau of Health Care Quality & Compliance

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NVS394AGC | A. BUILDING _____ B. WING _____ | 10/29/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST JOSEPH GROUP CARE 6 | 4028 E BOSTON AVENUE LAS VEGAS, NV 89104 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| Y 000 | Initial Comments<br><br>This Statement of Deficiencies was generated as a result of the annual State Licensure survey conducted at your facility. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.<br><br>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.<br><br>The facility was licensed for 6 total beds.<br>The facility had the following category classified beds: 6 Category 1 beds.<br><br>The facility had the following endorsements:<br><br>Residential facility for persons with mental illnesses.<br><br>The census at the time of the survey was 6 residents.<br><br>Six (6) resident files and 4 employee files were reviewed.<br><br>The following regulatory deficiencies were identified: | Y 000 | | |
| Y 178 SS=F | 449.209(5) Health and Sanitation-Maintain Int/Ext<br><br>NAC 449.209<br>5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are | Y 178 | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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| Y 178 | Continued From page 1<br>well maintained.<br><br>This Regulation is not met as evidenced by:<br>Based on observation during the initial facility tour on 10/29/2008, the air conditioning return vent failed to be clean.<br><br>Findings include:<br><br>Interview:<br><br>The caregiver stated that the vent was scheduled to be cleaned and the filters to be changed the following day.<br><br>Observation:<br><br>The facility failed to ensure that the area around the air conditioning return vent was clean.<br><br>Severity: 2 Scope: 3 | Y 178 | | |